

BUPRENORPHINE – SUBOXONE[®] EXEMPTION REQUEST

INTRODUCTION

In order for the Department of Social and Health Services, Medical Assistance Administration (MAA) to consider an exemption for the patient below, complete this form and return to DASA by **fax (360) 438-8057**. If an exemption is granted, the physician, the chemical dependency treatment agency, and the Pharmacy will need to complete a new **Buprenorphine -- Suboxone[®] Authorization** form (DSHS 13-720) prior to dispensing the medication.

1. PATIENT INFORMATION

PATIENT'S NAME	PATIENT'S MAA PIC NUMBER	DIAGNOSIS <input type="checkbox"/> Opiate Dependent	DATE
NAME OF THE DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA) CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY		AGENCY NUMBER (USE NUMBER IN GREENBOOK "DIRECTORY OF CERTIFIED SERVICES IN WASHINGTON")	

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ (print patient's name) authorize the physician indicated below to disclose my name and other personal identifying information, my status as a patient, my diagnosis, and their treatment recommendation(s) to the Division of Alcohol and Substance Abuse (DASA). The purpose of the disclosures authorized in this consent is to obtain a prescription for Buprenorphine -- Suboxone[®]. I understand that generally my physician may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

I understand that my MEDICAL records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 Code of Federal Regulations, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **either 90 days from the date signed, or the following specific date, event, or condition upon which this consent expires:**

(date/event/condition)

PATIENT'S SIGNATURE	DATE	SIGNATURE OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE (WHEN REQUIRED)	DATE
---------------------	------	---	------

2. PHYSICIAN SECTION

PHYSICIAN'S PRINTED NAME	TELEPHONE NUMBER	MEDICAID PROVIDER NUMBER OR DEA ID NUMBER
PHYSICIAN'S SIGNATURE	FAX NUMBER	E-MAIL

PHYSICIAN'S DECLARATION: Up to a six-month exemption has been discussed with the above patient. The patient and physician understand that only one six-month exemption to the limitation of MAA's payment for the prescription will be granted.

SINCE SUBOXONE [®] RATE CURRENT LEVEL:	Decreased	Same	Increased	Can't tell	n/a
ER VISITS					
HOSPITAL ADMISSIONS					
CRIMINAL BEHAVIOR					
HOMELESSNESS					
PRODUCTIVE ACTIVITY; WORK, OR SCHOOL					
USE OF DRUGS AND/OR ALCOHOL					
PARTICIPATION IN CHEMICAL DEPENDENCY TREATMENT					
PARTICIPATION IN MENTAL HEALTH TREATMENT					
COMPLIANCE WITH PSYCHIATRIC MEDICATIONS					
STABILITY OF PATIENT'S HOME ENVIRONMENT/SOCIAL RELATIONSHIPS					
BEHAVIORAL PROBLEMS					

CLINICAL JUSTIFICATION FOR EXEMPTION: (TO BE FILLED OUT BY PRESCRIBING PHYSICIAN)

Submit form to: DSHS/DASA, Attn: Deb Cummins, Certification Policy Manager, at fax (360) 438-8057. For questions regarding this form or exemption process, call (360)725-3716 or Toll Free 1-877-301-4557, or e-mail cummid@dshs.wa.gov.

FOR DASA USE ONLY:	APPROVED <input type="checkbox"/>	DENIED <input type="checkbox"/>	BASED ON: _____
DASA SIGNATURE: _____	DATE _____		RESPONSE SENT <input type="checkbox"/> DATE _____

BUPRENORPHINE – SUBOXONE[®] EXEMPTION REQUEST FORM INSTRUCTIONS

What is the purpose of an exemption request? DSHS Medical Assistance Administration (MAA) initially pays for the Buprenorphine – Suboxone[®] prescription for up to six months. The exemption requests MAA to pay for up to an additional six-month prescription.

Where is the completed form sent?

Fax completed form to DSHS/DASA at:

Attn: Deb Cummins, DASA Certification Policy Manager / DSHS

Fax # (360) 438-8057

If you do not have a fax, then mail to: DSHS/DASA, Deb Cummins, Certification Policy Manager, Post Office Box 45330, Olympia, Washington 98504-5330.

How is the form completed?

1. Complete the PATIENT INFORMATION:

- Enter patient name, patient MAA Patient Identification Code (PIC) number; check diagnosis box, and date form completed.
- Enter the name of the Certified Chemical Dependency Treatment Agency that the patient is attending and the agency number.
- Complete **PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION** with patient. (Note: expiration date of authorization is 90 days from signing, unless otherwise indicated.)
- Patient must sign authorization (Exemption is not valid without patient's signature).

2. Complete the PHYSICIAN SECTION:

- Print the name of the physician, the physician's telephone number, and the physician's Medicaid Provider Number or DEA ID Number.
- Signature of physician; enter fax number and e-mail, if available.
- Review exemption limitation with patient.
- Complete grid. Check one appropriate box for each category.
- Write a brief clinical justification for the exemption. If you need more space, use additional paper and submit it with the form. Make sure to put the patient name, physician name, and date on the additional paper.
- Submit the completed form by fax to DSHS/Division of Alcohol and Substance Abuse (DASA), Certification Policy Manager, fax (360) 438-8057.

How does DSHS/DASA process the exemption?

A determination will be made by DASA within three working days upon receipt of exemption form. The form will be routed to MAA for final determination of approval. MAA will notify the physician and pharmacy by telephone or fax about the determination. An approval of the exemption will provide the patient with up to an additional six months of payment authorization for Buprenorphine - Suboxone[®]. No additional exemptions will be granted.

What steps do I take if the exemption has been granted?

Complete and submit a new Buprenorphine – Suboxone[®] Authorization form (DSHS 13-720). This form must be completed by the prescribing Physician, Chemical Dependency Treatment Agency, Chemical Dependency Professional (CDP), and Pharmacy prior to dispensing the medication.

Information about Patient's Right to Revoke Authorization:

A revocation requires only that a line be drawn through the document, with the word "Revoked," and the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including the telephone, provided their identity is confirmed